RESET

STATE OF TENNESSEE GROUP INSURANCE PROGRAM
REQUEST FOR RETROACTIVE TRANSACTION

State of Tennessee • Department of Finance and Administration • Division of Insurance Administration
13th Floor • William R. Snodgrass TN Tower • Nashville, Tennessee 37243 • 615-741-3590/1-800-253-9981 • Fax: 615-741-8196

Please type or print.

PART 1

Agency Name	Budget Code
Employee Name	SSN

PART 2

Please indicate the reason(s) for the requested retro. Attach this form to a copy of the Enrollment/Change Application and/or Leave Request Form and send to the Division of Insurance Administration. You should retain a copy for your records. **Refunds will only be issued for 3 months.**

Cancel Coverage	❑ Employee ❑ Dependent SSN _____	Effective Date _____ Program IDs _____ Reason _____
Reinstate Coverage	❑ Employee ❑ Dependent SSN _____	Program IDs _____ Reason _____
Change Effective Date	❑ Employee ❑ Dependent SSN _____	Effective Date _____ Program IDs _____ Reason _____
Change Coverage Type	❑ Family ❑ Single ❑ Split ❑ Single Split	Effective Date _____ Program IDs _____ If Split coverage: Spouse Name _____ Spouse SSN _____
Employee Should Have Been Placed on Leave of Absence	❑ Continue Coverage (Code 21) ❑ Suspend Coverage (Code 22)	Effective Date _____ If Code 22, date coverage to be termed _____ (must be last day of the month)

PART 3

Insurance Preparer Signature	Date